Miami-Dade Public Housing Agency
Housing Choice Voucher Program
Florida Quadel, Contractor
P.O. Box 521750
Miami, FL 33152-1750
T 305-403-3222 F 305-629-1032
TDD/TTY Florida Relay Service,
800-955-8771 or Dial 711
miamidade.gov

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Dokiman sa a enpòtan, tradui li tousuit!

REASONABLE ACCOMMODATION REQUEST

Head of Household:_____ Phone: (____)_____
(PRINT NAME)

Requestor:_____
(PERSON REQUESTING REASONABLE ACCOMMODATION IF OTHER THAN HEAD OF HOUSEHOLD, PRINT NAME)

Address: _____Client #:_____

Signature:_____
(HEAD OF HOUSEHOLD, OTHER REQUESTOR, OTHER REQUESTOR, OR AUTHORIZED REPRESENTIVE OF REQUESTOR)

A disability is defined, in part, as a physical or mental impairment that substantially limits one or more major life activities; a record of having such an impairment; or being regarded as having such an impairment.

A Public Housing resident may request a change in his or her current unit or a transfer to a unit that has already been changed (in the resident's development or another development). An applicant, resident, or program participant may request assistance with, or change in, a MDHCV practice, rule, policy, procedure, program or service.

MDHCV will work with the applicant, resident or program participant to determine how to provide the reasonable accommodation request. MDHCV may require documentation to support the reasonable accommodation request(s).

1. The following is the name of the household member with a disability who needs a reasonable accommodation:

   Name: _____

2. Because of the above household member's disability, the following change(s) or assistance (reasonable accommodation) is necessary so that the individual can participate in a Miami-Dade Housing Choice Voucher (MDHCV) program as easily or successfully as other program participants. Check the kind of change(s) you need.

   [ ] A change or special feature in a MDHCV dwelling, building or property. **Note: If you are a Section 8 program participant, you must make these kinds of requests to your landlord.**

   [ ] Assistance with, or change in, a MDHCV practice, rule, policy, procedure, program or service.

3. Describe the problem that the household member named in item 1 is having, or might have, with a MDHCV dwelling, building, property, practice, rule, policy, procedure, program or service:

   _____

   _____

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4. Describe the type of change or assistance (reasonable accommodation) required:

_____

_____

5. Describe how this change or assistance will help with the problem:

_____

_____

6. Indicate the verification source MDHCV may contact to verify that the household member named in item 1 has a disability and needs a reasonable accommodation.

Name of Health Care Provider/Documenting Authority	**Title**
Company	
Address	**Telephone Number**
City **State** **Zip Code**	**Fax Number**

Note: Individuals may obtain a copy of the MDHCV Reasonable Accommodation Policies and Procedures, upon request, from Public Housing Site Managers, Section 8 Leasing and Contract Specialists, and the ADA Coordinator. You may also get additional copies of this request form from the ADA Coordinator:

ADA Coordinator
7415 Corporate Center Drive, Bay C
Miami, Florida 33126
(305) 403-3222 phone
(305) 629-1032 fax
Florida Relay Service: (800) 955-8771 (TDD/TTY)

This material is available in an accessible format upon request. Please call the ADA Coordinator at (305) 403-3222 (phone) – Florida Relay Service (800) 955-8771 (TDD/TTY).

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REASONABLE ACCOMMODATION AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Household member with disability: _____

I hereby authorize the release of information to Miami-Dade Housing Choice Voucher program (MDHCV) regarding the request for reasonable accommodation described on this form. This release shall constitute a limited authorization for the release of information, as described below.

I hereby authorize _____ to consult with representatives of MDHCV, in writing, in person, or by telephone concerning the physical or mental impairment(s) that I assert to qualify as a individual with a disability for the sole purpose of this reasonable accommodation request.

For purposes of this Release, a "Qualified Individual With a Disability" is defined as a person who has a physical or mental impairment that:

1. Substantially limits one or more major life activities
2. Has a record of such an impairment
3. Is regarded as having an impairment

"A Physical or Mental Impairment" is defined as:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the body systems including, but not limited to: neurological, musculoskeletal, special sense organs, respiratory, and speech organs; **or**
2. Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

The term "Physical or Mental Impairment" includes, but is not limited to, such diseases and conditions as visual, speech and hearing impairments, epilepsy, multiple sclerosis, cancer, etc.

"Major Life Activities" include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a Record of Such an Impairment (mental or physical)" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Is Regarded As Having an Impairment" means:

1. Has a physical or mental impairment that does not substantially limit one or more major life activities, **but** is treated by a recipient as constituting such a limitation.
2. Has a physical or mental impairment that substantially limits one or more major life activities **only as a result of** the attitudes of others toward the impairment.
3. Has none of the impairments defined by Section 504's definition of "physical or mental impairment", **but** is treated by a recipient as having such an impairment.

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In addition, I authorize _____ to provide only documentation that is necessary to verify that I meet the definition of a "Qualified Individual with a Disability", as defined above.

This Authorization solely authorizes the release of information necessary to verify the following:

1. Documentation necessary to verify that the person meets the definitions noted above;
2. A description of the needed accommodation; and,
3. A description of the identifiable relationship between my disability and the requested accommodation(s).

This Authorization for Release of Information should only seek information that is necessary to determine if the requested reasonable accommodation is needed because of a disability.

This Authorization does **not** authorize MDHCV to examine my medical records, including diagnosis or test result(s); nor does this authorize the release of detailed information about the nature or severity of my disability.

The information/documentation released as a result of this Authorization shall be kept confidential and not shared with anyone unless required to make or assess a decision to grant or deny a reasonable accommodation request.

_____ _____

Name of Family Member/Parent/Legal Guardian [Print] *Relationship to Person with Disability*

_____ _____

Signature *Date*

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of Health Care Provider/Documenting Authority **Title**

Company

Address **Telephone Number**

City **State** **Zip Code** **Fax Number**

This material is available in an accessible format upon request. Please call the ADA Coordinator at (305) 644-5187 (phone) – Florida Relay Service (800) 955-8771 (TDD/TTY).

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REASONABLE ACCOMMODATION VERIFICATION

Head of Household: _____ Participant/Client No: _____
(PRINT NAME)

Re: **Reasonable Accommodation Request**

For: _____ Telephone: (_____) _____
(PRINT NAME OF HOUSEHOLD MEMBER FOR WHOM THE REQUEST IS BEING MADE)

PLEASE RETURN TO: _____ MDHCV Phone: 305-403-3222
(MDHCV Employee Name)

Miami-Dade Housing Choice Voucher Program
PO Box 521750
Miami, FL 33152-1750

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE DESIGNATED VERIFICATION SOURCE:

1. The individual seeking an accommodation is a person with a disability according to the following definition: *"Disability" is defined as a physical or mental impairment that substantially limits one or more major life activities; a record of having such impairment, or being regarded as having such impairment*.

   ☐ YES ☐ NO

2. Describe the problem(s) that the person is having with the MDHCV dwelling, building, property, practice, rule, policy, procedure, program or service:

3. Describe the type of change(s), feature(s) or assistance required:

4. Using the checklist on the following page, indicate the functional limitation(s) (i.e. the way major life activities are substantially limited) of the person for whom the accommodation is requested.

5. Please describe the relation between the person's functional limitation(s) and the requested accommodation. Do not provide unnecessary details about the medical history or disabled status of the person seeking an accommodation.

Name of Verification Source	**Title**
Company	**Signature** **Date**
Address	**Telephone Number** **Fax**

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CLIENT'S NAME: _____ **CLIENT #:** _____
Last First

TYPE OF MAJOR LIFE ACTIVITIES *(Check applicable)*	**DISABILITY STATUS** **D**= Disabled* (or) **ND**= Not Disabled *(Enter D or ND as applicable)*
☐ Walking	
☐ Standing	
☐ Climbing	
☐ Bending	
☐ Stooping	
☐ Kneeling	
☐ Use of Hands	
☐ Reaching	
☐ Self Care	
☐ Speaking	
☐ Breathing	
☐ Seeing	
☐ Hearing	
☐ Lifting	
☐ Intelligence (a person's capacity for understanding)	
☐ Thinking (the ability to form or conceive in the mind)	
☐ Perception (the brain's interpretation of internal and external stimuli)	
☐ Judgment (the ability to assess a given situation and act appropriately)	
☐ Mood (emotional tone underlying the behavior)	
☐ Behavior (specifically examining behavior that is disruptive, distressing or aggressive)	
☐ Other (Please Specify in non-technical terms that simply describe what the client cannot do or has difficulty doing)	
HEATH CARE PROVIDER/VERIFICATION SOURCE INFORMATION **PRINT NAME:** _____	**SIGNATURE:** _____**DATE**____/____/____ **TELEPHONE NUMBER (** ____**)**_____
NOTES (use additional sheet if necessary):	

* ***"Disability"*** *is defined as a physical or mental impairment that substantially limits one or more major life activities.*